

## 3 Vision Guidelines

3.1	Introduction .....	3-1
3.1.1	General Policy .....	3-1
3.1.2	Client Eligibility .....	3-1
3.1.3	Reimbursement .....	3-1
3.1.4	Attachments.....	3-1
3.1.5	Medicare Crossovers for Vision Services.....	3-1
3.1.6	Third Party Recovery .....	3-2
3.1.7	Place of Service Codes .....	3-2
3.1.8	Prior Authorization .....	3-3
3.2	Vision Service Policy .....	3-4
3.2.1	Overview.....	3-4
3.2.2	Covered Services and Limitations for All Medicaid Clients .....	3-4
3.2.3	Covered Services For Clients Up To Age 21 (EPSDT) .....	3-6
3.2.4	Covered Services For Clients Age 21 And Older .....	3-6
3.2.5	Exclusions and Limitations .....	3-7
3.2.6	Procedure Codes.....	3-7
3.3	Claim Billing.....	3-10
3.3.1	Which Claim Form to Use.....	3-10
3.3.2	Electronic Claims.....	3-10
3.3.3	Guidelines for Paper Claim Forms .....	3-11

## 3.1 Introduction

### 3.1.1 General Policy

This section covers all Medicaid vision services provided through Opticians, Optometrist (Medical/Certification), and Optometrist specialties as deemed appropriate by IDHW. These specialties are identified as vision services throughout this section.

### 3.1.2 Client Eligibility

Clients who are covered under a restricted program will not have vision benefits. These programs include, but are not limited to, the following:

- Ineligible Aliens
- Pregnant Women
- Presumptive Eligibility
- Qualified Medicare Beneficiary program only, without another unrestricted program open
- Clients who are on Lock-In for emergency services only

### 3.1.3 Reimbursement

Medicaid reimburses vision services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

### 3.1.4 Attachments

Most vision claims do not require attachments. They would only be needed when identified in this handbook section.

### 3.1.5 Medicare Crossovers for Vision Services

When a client has Medicare and Medicaid, Medicare must be billed before a claim is submitted to Medicaid. In most cases, Medicare claims automatically cross over to Medicaid for payment. If the claim does not cross over, bill electronically with the proper documentation or submit a CMS-1500 claim form and attach a copy of the Medicare Remittance Notice (MRN).

Reimbursement for crossover claims is based on the Medicaid allowed amount and will be the lower of the Medicare allowed amount, the Medicaid allowed amount, or the billed amount. Medicare covered and non-covered services should be billed on separate claim forms.

Clients that have QMB (Qualified Medicare Beneficiary) coverage *only*, are not eligible for Medicaid. SWEEP does not provide glasses/contacts for clients with QMB-only coverage. MAVIS eligibility verification (Medicaid Automated Voice Information System) identifies QMB-only clients with this comment: "Benefits are restricted to Medicare paid services".

Clients who are covered by both QMB and another unrestricted Medicaid program (dually eligible), are entitled to Medicaid benefits, which include eye exams and SWEEP glasses/contacts. MAVIS lists "*Medicaid benefits*" for a specific date of service, and "*Additional coverage for Medicare paid services.*" *For Medicaid reimbursement, all frames, lenses, or contacts must be ordered from SWEEP.*

### 3.1.6 Third Party Recovery

See **Section 2, General Billing Information, Third Party Recovery**, regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

Since most third party resources do not reimburse for fitting fees, that service may be billed directly to Medicaid without an insurance EOB (Explanation of Benefits) or denial. See **Section 3.2.6** for fitting fee codes.

Idaho Medicaid covers frames, lenses, and contacts only when provided by SWEEP Optical. If a Medicaid client has other insurance coverage that utilizes an alternate provider of vision hardware, the client must choose between SWEEP and the 'Non-SWEEP' provider.

If a client chooses a non-SWEEP product, the vision hardware is not reimbursable by Medicaid.

If the Medicaid client has vision benefits from a third party insurance and vision benefits from Medicaid, the following guidelines must be followed:

- Provider must place an order through SWEEP Optical
- SWEEP provides products ordered (frames and/or lenses) to provider
- SWEEP will bill the provider for the products supplied at the same rate SWEEP charges Medicaid
- Provider bills the Third Party Insurance (TPI) for product and/or supplies
- Provider receives an EOB and payment from TPI
- Provider sends EOB to SWEEP (regardless of whether or not any money was paid on the claim)
- SWEEP forwards the EOB to Medicaid
- Medicaid will reimburse SWEEP for unpaid expenses not covered by TPI
- SWEEP credits the amount received from Medicaid to the vision provider

### 3.1.7 Place of Service Codes

All vision and optician services are processed with the following place of service code:

**11 — Office**

#### 3.1.7.1 Healthy Connections

Check eligibility to see if the client is enrolled in Healthy Connections (HC), Idaho's Medicaid care management program. If a client is enrolled in the HC program, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. Refer to **Section 1.5, General Provider and Client Information, Healthy Connections**, for more information.

Vision services performed in the offices of ophthalmologists and optometrists, including the dispensing of eyeglasses, do not require a HC referral. Procedures performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work. The HC referral must be obtained from the client's primary care physician (PCP).

### 3.1.8 Prior Authorization

The following services require prior authorization (PA) from Medicaid:

- Polycarbonate lenses which do not meet criteria (see Section 3.2.2.3)
- Aspheric lenses
- High Index lenses
- Tints
- Contact lenses

If prior authorization is required, the prior authorization number must be indicated on the claim or the service payment will be denied. When billing, write the PA number in field 23 of the CMS-1500 claim form. For electronic claims, enter the PA number in the prior authorization field on the screen.

Prior authorizations are valid for two (2) months from the date of authorization by Medicaid unless otherwise indicated on the approval.

Include the prior authorization number on the State designated SWEEP order form for these services.

A copy of the Vision Prior Authorization Request form is available in the Forms Appendix. Requests for Department authorization must include the client's name, Medicaid identification number, and a copy of the client's prescription. If a tint is being requested, include the diagnosis for the medical condition that requires the tint.

Fax requests to (208) 332-7280

Mail requests to:

Division of Medicaid  
Vision Services Prior Authorization  
P.O. Box 83720  
Boise, ID 83720-0036

EDS is not an authorizing agency for any Medicaid services and does not issue prior authorization.

## 3.2 Vision Service Policy

### 3.2.1 Overview

Order all vision supplies (frames, lenses, contact lenses) from SWEEP Optical in Eugene, Oregon. Sweep Optical will bill Medicaid for the supplies. The optical provider bills Medicaid for the examination, a fitting or dispensing fee, and repairs when repair guidelines are met.

Contact SWEEP Optical at (800) 984-3204 for information on placing orders and ordering samples. FAX orders to (800) 383-1828.

Medicaid covers one complete visual examination annually (365 days) to determine the need for eyeglasses to correct a refractive error. Eligible clients who have a diagnosis of visual defects, and need eyeglasses to correct a refractive error, can receive eyeglasses within the guidelines defined in this section.

Additional eye examinations may be paid in the following instances: when there is a documented visual correction needed that is equal to or greater than plus or minus .50 diopter per eye and/or reasonable medical justification.

While Medicare allows the use of evaluation and management codes for eye examinations, Medicaid requires the appropriate eye exam procedure code to be billed. Evaluation and management procedures are paid only for an eye injury or disease.

Submit all eyeglass and contact lens orders to the following address:

SWEEP Optical  
2145 Centennial Plaza  
Eugene, OR 97401-2421

Phone: (800) 984-3204  
FAX: (800) 383-1828

### 3.2.2 Covered Services and Limitations for All Medicaid Clients

#### 3.2.2.1 Fitting Fee

A fitting fee may be billed when the client is eligible for new frames or lenses and they are ordered from SWEEP Optical. A fitting fee may be billed for replacement glasses if a notation of the valid replacement is indicated on the claim (i.e., major visual change for all ages, or broken/lost/outgrown eyeglasses for under age 21).

#### 3.2.2.2 Tinted, Photochromatic and Transition Lenses

Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department. Tinted lenses are only payable when prior authorized by the Department. Tinted lenses for cosmetic reasons are not covered by Medicaid.

Clients who desire additional features added to their prescription lenses that are not covered by Medicaid may pay separately for them. SWEEP Optical

**Note:**

Optometrists who have a provider agreement allowing payment for the treatment of injury or disease of the eye may bill the services using the appropriate CPT codes. Contact EDS provider enrollment unit for more information on how to become an approved provider.



To see the complete catalog of frames and to place on-line orders, go to SWEEP Optical on the Web:

[www.sweepoptical.com](http://www.sweepoptical.com)

will bill the provider separately and the provider may bill the client their usual and customary charge for tints, photochromatic, and transition lenses options. If the client cannot adapt to their new lenses, the client is responsible for any replacement of the lenses.

### **3.2.2.3 Polycarbonate Lenses**

Polycarbonate lenses are covered only when the correction required is above plus or minus 2.00 diopters per eye. Requests that meet this criterion may be ordered directly from SWEEP Optical by noting "Polycarbonate Lenses Requested" under Special Instructions on the SWEEP Optical Order Form. Requests for orders that do not meet the criteria will not be completed and must be prior authorized by the Department. Fax requests to (208) 332-7280 or mail to the address in **Section 3.1.8, Prior Authorization**.

### **3.2.2.4 Aspheric Lenses**

Aspheric lenses are covered only when the client has a plus 8.00 diopter reading or higher. Prior authorization is required by the Department.

### **3.2.2.5 High Index Lenses**

High Index lenses are covered only when the client has a minus 4.00 diopter reading or higher. Prior authorization is required by the Department.

### **3.2.2.6 Contact Lenses**

Contact lenses will be payable only with a myopic condition requiring a correction equal to or greater than minus 4.00 diopter per eye, or when cataract surgery, keratoconus, or other medical condition as defined by the Department precludes the use of conventional lenses. Contact lenses and regular lenses prescribed in the same year are not payable by Medicaid. Prior authorization is required from the Department. Contacts are not covered for cosmetic or convenience purposes.

### **3.2.2.7 Bandage Lenses**

Bandage lenses are covered with prior authorization from the Department for patients who have had cataract surgery.

### **3.2.2.8 Refraction Procedures**

When billing for refraction, use procedure code **92015**. This service is allowed once every 365 days. Additional exams must be prior authorized by the Department. Determination of refractive state includes specification of lens type, lens power, axis, prism, absorptive factor, impact resistance, and other factors.

### 3.2.3 Covered Services For Clients Up To Age 21 (EPSDT)

#### 3.2.3.1 Additional Eye Examinations

An exception to the annual limit for eye examinations is the need for additional eye examinations and lenses when identified during an EPSDT screening visit. Prior authorization is required.



Send request to:

Division of Medicaid  
EPSDT Coordinator  
P.O. Box 83720  
Boise, ID 83720-0036

Phone Number: (208) 364-1842  
FAX Number: (208) 332-7280

EDS is not an authorizing agency for any Medicaid services and does not issue prior authorization.

#### 3.2.3.2 Repairs/Replacement

Prior authorization is not required for repair or replacement of lost glasses, broken or outgrown frames, or damaged or lost lenses for clients under the age of 21 unless the original frame or lenses required a prior authorization. Follow directions for obtaining a prior authorization in section 3.1.8. If the broken frames can be repaired for less than the cost of the new frames, the frames should be repaired. If the repair costs are greater than the cost of new frames, new frames should be dispensed. However, the provider must justify, on the SWEEP order form, the reason for the service requested.

#### 3.2.3.3 Frames

Frames are covered once every 365 days (rolling year) if needed for clients under the age of 21. Frames will not be replaced unless criteria for replacement are met as outlined in Section 3.2.3.2.

#### 3.2.3.4 Lenses

Lenses are covered once every 365 days (rolling year) for clients under the age of 21. Additional lenses are covered if the criteria for replacement are met as outlined in Section 3.2.3.2.

### 3.2.4 Covered Services For Clients Age 21 And Older

#### 3.2.4.1 Frames

Medicaid will purchase eyeglasses for clients age 21 and older and dispense one set of frames once every four years. Medicaid may authorize new frames within the four-year period, when a physician or optometrist documents a major change in visual acuity that cannot be accommodated in lenses that fit in the existing frame. Medicaid will not pay for broken, lost, or missing frames or damaged or lost lenses for clients age 21 years of age and older within the four-year period.

### 3.2.4.2 Repairs

Repairs on frames due to a manufacturer's defect are covered for 90 days. Repairs that involve the replacement of a temple or front must be submitted to SWEEP Optical for repair. Exceptions are:

- There is documentation in the client's record that the client cannot function safely without the glasses for the time necessary to send the glasses to SWEEP for repairs.
- The client does not have back up glasses to use while the glasses are being repaired.

SWEEP Optical will provide the replacement parts and the provider can bill Medicaid for the repairs using HCPCS code 92370 only if the above exceptions are met.

### 3.2.4.3 Lenses

Additional lenses may be covered when there is a documented visual correction change that is equal to or greater than plus or minus .5 diopter in one or both eyes (not a combined total correction for both eyes) or a major add on such as the need for bifocals has been added to the prescription.

## 3.2.5 Exclusions and Limitations

### 3.2.5.1 Eye Exercise Therapy

Medicaid does not pay for eye exercise therapy.

### 3.2.5.2 Trifocal and Progressive Lenses

Trifocal and progressive lenses are not covered but Medicaid will pay for the bifocal portion of the lenses. **No-line (progressive) lenses are not covered and Medicaid does not cover the cost of remaking the lenses when a client cannot adapt to these lenses. If the client requests the lenses to be remade due to his/her inability to adapt to the progressive lenses, the client will be responsible for the charges. Be sure the client is aware of this policy before placing the order.** A client who desires trifocal or progressive prescription lenses may pay separately for the difference between the usual and customary charge for bifocal lenses and the usual and customary charges for trifocal or progressive lenses. SWEEP Optical will bill the provider separately and the provider may bill the client their usual and customary charge.

## 3.2.6 Procedure Codes

Bill vision services using the appropriate CPT or HCPCS codes as listed in the current procedural coding books. Optometrists who have a provider agreement allowing payment for the treatment of injury or disease may also use codes from the CPT Manual. See **Note** under **3.2 Vision Service Policy**. Listed below are codes with specific Medicaid limitations and/or additional billing information.

Service	Code	Description and Limitations
Determination of Refractive State	92015	Allowed once every 365 days.
Tonometry	92100	Tonometry is considered included within a comprehensive visual exam. If an additional separate tonometry is needed, Medicaid will allow one additional tonometry within the same 365-day period as the comprehensive exam. This limitation does not apply to clients receiving ongoing treatment for glaucoma.
Fitting Fee	92340 92341 92342	<i>92340 Fitting of spectacles, except for aphakia, monofocal</i> <i>92341 Fitting of spectacles, except for aphakia, bifocal</i> <i>92342 Fitting of spectacles, except for aphakia, multifocal, other than bifocal</i>
Corneal Pachymetry	76514	Corneal pachymetry, unilateral or bilateral, to determine corneal thickness.
Trichiasis	67820 67825	Report code 67820 once per day even if multiple procedures were performed on different eyelids and/or eyelashes. Report code 67825 once per day when cryosurgery or electrosurgery is performed.

### 3.2.6.1 Comprehensive Visual Examination

A comprehensive visual examination includes the following professional and technical vision services:

- History
- General medical observation
- External and ophthalmoscopic examinations
- Determination of best corrected visual acuity
- Gross visual fields
- Basic sensorimotor examination
- Refractive state
- Initiation of diagnostic and treatment programs

**Note:** Initiation of diagnostic and treatment programs include:

- Prescription of medication
- Arranging for special ophthalmological diagnostic or treatment services
- Consultations
- Laboratory procedures
- Radiological services

**Note:** Special ophthalmological services include interpretation and report by the physician/optometrists. Technical procedures (which may or may not be performed by the physician personally) are often part of the services but should not be mistaken to constitute the service itself.

Do not itemize service components such as:

- Slit lamp examination
- Keratometry
- Routine ophthalmoscopy
- Retinoscopy
- Refractometry
- Tonometry
- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Motor evaluation

## 3.3 Claim Billing

### 3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the claim date of service.

### 3.3.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See **Section 2** for more information on electronic billing.

#### 3.3.2.1 Guidelines for Electronic Claims

##### Detail lines

Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

##### Referral number

A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections, enter the provider's Healthy Connections referral number.

##### Prior authorization (PA) numbers

Idaho Medicaid allows more than one prior authorization number on electronic HIPAA 837 professional claims. PA numbers can be entered at the header or detail of the claim in the appropriate field.

PAs for eyeglasses, lenses, or contacts are only used by SWEEP Optical for billing Medicaid. Vision service providers must note the PA number on the order to SWEEP Optical.

##### Modifiers

Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

##### Diagnosis codes

Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

See **Section 3.3.3.4** for instructions on completing specific fields.

##### Electronic crossovers

Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

### **3.3.3 Guidelines for Paper Claim Forms**

For paper claims, use only original red CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07/04/2006

#### **3.3.3.1 How to Complete the Paper Claim Form**

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

#### **3.3.3.2 Where to Mail the Paper Claim Form**

Send completed claim forms to:

EDS  
P.O. Box 23  
Boise, ID 83707

### 3.3.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be delayed when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable.  This field can also be used to enter the ICN of previous claims to establish timely filing.

Field	Field Name	Use	Directions
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from Medicaid.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). <b>Example:</b> November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an <b>X</b> .
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payments including Medicare. If the OI payment is 40% or less, attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field (field 29).
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.

Field	Field Name	Use	Directions
33	GRP # — Group Provider Number  PIN # --- Individual Provider Number	Required	Enter the nine-digit Medicaid group provider number if applicable.  Enter the nine-digit Medicaid individual provider number if applicable.

## 3.3.3.4 Sample Paper Claim Form

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

HEALTH INSURANCE CLAIM FORM														
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA  <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) </div> <div> <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) </div> </div>														
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.							
<p align="center"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p>														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____									
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER					24. A B C D E F G H I J K DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSTD Family Plan EMG COB RESERVED FOR LOCAL USE				
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
SIGNED _____ DATE _____					PIN# _____ GRP# _____									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)  
APPROVED CMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500